STATE OF MINNESOTA

OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE COMMISSIONER OF HEALTH

In the Matter of Greeley Healthcare Center Survey Date: June 29, 2005

RECOMMENDED DECISION

The above matter was the subject of an informal dispute resolution meeting conducted by Administrative Law Judge Kathleen D. Sheehy on October 18, 2005, at 9:30 a.m. at the Office of Administrative Hearings. The meeting concluded on that date.

Marci Martinson, Unit Supervisor, Division of Facility and Provider Compliance (DPFC), 1645 Energy Park Drive, Suite 300, St. Paul, MN 55108-2970, appeared on behalf of DFPC. Mary Cahill also attended the meeting for the Department of Health.

Michelle R. Klegon, Esq., Voigt, Klegon & Rode, LLC, 2550 University Avenue W., Suite 190, St. Paul, Minnesota 55114, appeared on behalf of the Greeley Healthcare Center (the facility). The following persons made comments on behalf of the facility: Tom Fontaine, Maintenance Director; Chris Palmer, Director of Nursing; Matthew Kern, Executive Director; and Kara Ehrman of Aegis Therapies.

NOTICE

Under Minn. Stat. § 144A.10, subd.16(d)(6), this recommended decision is not binding on the Commissioner of Health. Under Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the facility indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge within 10 calendar days of receipt of this recommended decision.

FINDINGS OF FACT

Tag F 164

1. Resident #23 is a 76-year-old man with dementia and other health problems. He has short-term memory problems and moderately impaired decision-making skills, but his communication skills are good and he has no problem speaking or making himself understood. He is at ease interacting with

others, doing planned or structured activities, and doing self-initiated activities.[1] His plan of care called for assisting him with his memory problems by giving him simple choices. He required no other interventions or strategies to deal with cognitive loss.[2] In June 2005 facility staff documented a recent loss of weight and a decline in his ability to eat.[3]

2. An occupational therapist from Aegis Therapies came to the facility on June 28, 2005, to assess his weight loss and decreased interest in eating.[4] She arrived at about 1:50 p.m. and found the resident in the dining room, waiting for bingo to begin. The resident was sitting at one end of five four-foot tables that had been pushed together for bingo. At the other end of the table, about 20 feet away, were two other residents.[5] About eight other residents were in the dining room. He was eating a snack at the time. The therapist asked him if she could sit down and ask him a few questions, and he said yes.[6] There is no evidence that other residents in the room could hear what the resident and the therapist were discussing.

3. The therapist asked him some questions about where he lived and his weight loss, and she encouraged him to eat. She asked him to perform a hand coordination check by using his pinky finger to touch other fingers. After 15 minutes, the surveyor called the therapist out of the dining room to question her about whether the assessment should be done in private. The resident was then removed from bingo and taken to a therapy room to complete the assessment.[7]

4. When he returned to his room later that afternoon, the surveyor questioned him, and the resident said he did not like it when the therapist questioned him in front of others, and he did not like being taken out of bingo.[8] The next day facility staff asked him about the incident, and he signed a note stating that he gave permission to the therapist to ask him questions while playing bingo and that he did not feel like this was a violation of his privacy.[9]

5. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes medical treatment. The “right to privacy” means the resident has the right to privacy with whomever the resident wishes to be private and that this privacy should include full visual, and, to the extent desired, for visits or other activities, auditory privacy. People not involved in the care of the individual should not be present without the individual’s consent while the resident is being examined or treated.

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[1] Ex. C6-8.
[2] Ex. C14.
[3] Ex. C13.
[4] Ex. C34.
[5] Chris Palmer, Director of Nursing.
[6] Ex. C31, 39-40, 48.
[7] C31.
[8] Ex. C31.
[9] Ex. C48.

6. Form 2567 describes the incident but fails to include the fact that the therapist asked the resident for his permission to sit down and ask him some questions, and the fact that the resident consented to her request.[10]

Tag F 323

7. During the annual survey in May 2005, the survey team completed an environmental tour of the entire facility, and at that time all doors operated properly. When the surveyors returned on June 28 and 29, 2005, the weather was unusually humid, and some of the doors had swollen and were making contact with the door frames as indicated below.

8. When Resident #23 returned to his room after the occupational therapy assessment was completed at about 3:45 p,m., the surveyor noted that the door to the resident's room was closed, and it was difficult to open. She and the facility's executive director were able to open it only by pushing hard on it with their shoulders. The executive director said that he would have maintenance look at it and in the meantime he would inform the staff not to fully close the door.

9. The next morning at about 8:20 a.m., the surveyor was doing rounds and noticed that the door was partially closed and a blower or fan had been placed in the hallway outside the door. The executive director stated that the carpet had been cleaned and the door had wicked up some moisture, which the facility was trying to dry out with the fan. The surveyor informed the executive director that the door had to be fixed before she left the building. The executive director immediately called maintenance, and the door was removed, planed, and re-installed by 10:00 a.m.

10. The surveyor then checked all the entry doors on three units and found that seven others were "sticking." Unlike the door to Resident #23's room, these doors could be opened and closed, but they made some contact with the doorframes in the process.[11]

11. While checking the entry doors, a family member of another resident mentioned that the bathroom door was also sticking. The surveyor then checked all the bathroom doors on three units and found that eight others were sticking. Again, these doors could be opened and closed, but they made some contact with the doorframes.

12. Residents reported that the doors had been sticking for one to two weeks, but no one had reported a problem to staff until that day. One resident reported that she had been stuck in her bathroom for a short period of time before she was able to get out.

13. A housekeeper reported that doors had been sticking because of the high humidity, and a nursing assistant had reported that she had noticed

[10] Ex. B3. The surveyor's notes provide that "resident told staff he didn't mind an interview," but this statement was not included in the tag. *See* Ex. C31.
[11] Matthew Kern; Tom Fontaine.

problems during the last week. Neither of the staff members had reported the problems to maintenance.

14. The facility conducts monthly fire inspections followed by a fire drill. During the inspection, all entry doors (which are considered fire-rated) are checked for compliance with the fire code standard, which is that the door closes freely and latches. Daily maintenance activities include random door checks. There is a kiosk area at every nurse's station where maintenance requests are collected every day, and employees with computer access can report maintenance issues electronically.

15. All doors that had been sticking were repaired and re-installed within three hours of identification.

16. The facility must ensure that the resident environment remains as free of accident hazards as is possible. The intent of this provision is that the facility prevents accidents by providing an environment that is free from hazards over which the facility has control. Accident hazards are physical features in the environment that can endanger a resident's safety.[12]

17. The deficiency was cited at severity level 2, which is noncompliance that results in no more than minimal physical, mental, and/or psychosocial discomfort to the resident and/or has the potential to compromise the resident's ability to maintain and/or reach his/her highest practicable physical, mental and/or psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.

18. The deficiency was cited as a pattern, which occurs when more than a very limited number of residents are affected or the situation has occurred in several locations.

Based upon the exhibits submitted and the arguments made and for the reasons set out in the Memorandum that follows, the Administrative Law Judge makes the following:

RECOMMENDED DECISION

1. That the citation with regard to F-tag 164 is not supported by the facts and should be rescinded because there was no deficient practice.

2. That the citation with regard to F-tag 323 is supported in scope and severity.

[12] 42 C.F.R. § 483.25(h)(1).

Dated this 28th day of October, 2005.

s/Kathleen D. Sheehy
KATHLEEN D. SHEEHY
Administrative Law Judge

Reported: Tape-recorded (one tape, no transcript)

MEMORANDUM

With regard to F-tag 164, there is no dispute that the resident consented to speak to the therapist in the dining room. The DPFC contended at the meeting that the resident was not capable of consenting to meet with the therapist because he has dementia and impaired decision-making skills. The resident's care plan, however, provides that the resident is to make simple decisions about his care, and the director of nursing stated that he has known the resident for more than one year, that the resident has the ability to make simple day-to-day decisions, and that the resident has good communication skills.[13] The evidence is insufficient to conclude that the resident is not capable of providing consent under these circumstances. In addition, DPFC contended at the meeting that it was inappropriate and intimidating for the facility staff to question the resident the next day and ask him to document what had happened. DPFC is in no position to criticize the facility for trying to find out what happened, when it was aware the resident had consented to speak to the therapist and failed to include that information in the deficiency citation.

With regard to F-tag 323, the facility did have an on-going maintenance program and regular inspections of the doors. The Administrative Law Judge is aware that the record reflects that the weather was unusually hot and humid during the week before re-visit, and it is true that the facility cannot control the weather; however, the problems with the doors sticking were known to two staff members for about a week, and they did not report the problems or request repairs. If residents have to make extra effort to open or close doors, they could lose their balance or become "stuck" in their rooms, which would be an accident hazard.

The 2567 Form does not make clear that only one door had a severe problem, and the rest required far less work to fully correct. The Administrative Law Judge cannot conclude, however, that the scope and severity levels assigned were erroneous.

K.D.S.

[13] Chris Palmer, Director of Nursing.